Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN1796AGC	A. BUILDING _____ B. WING _____	09/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VALLEY GROUP CARE 2	1140 MANHATTAN ST RENO, NV 89512

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Y 000	Initial Comments This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 8/29/08 and completed on 9/8/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was nine. Nine resident files were reviewed and two employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000		
Y 072 SS=C	449.196(3) Qualications of Caregiver-Med re-training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau.	Y 072		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 072	Continued From page 1 This Regulation is not met as evidenced by: Based on record review on 8/29/08, the facility did not ensure 1 of 2 employees met the medication re-training requirement and the facility did not ensure 1 of 2 employees had documentation of original medication training. Finding include: The file for Employee #2, the administrator, contained a medication training certificate dated 5/21/05. The facility did not have evidence the employee had completed at least three hours of medication re-training. The file for Employee #1 contained a three hour medication retraining certificate dated 6/23/07. The file did not contain evidence the employee had completed an initial medication training and passed an approved examination. Severity: 1 Scope: 3	Y 072		
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order.	Y 878		

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Y 878	Continued From page 2 This Regulation is not met as evidenced by: Based on record review and interview on 8/29/08, the facility did not ensure "as needed" (PRN) medications were being administered as prescribed for 3 of 3 residents with PRN medications. Findings include: (See TAG YA908) Resident #4 was prescribed Tramadol HCL 50 mg, one tablet every six hours PRN for pain. The facility documented on the August 2008 that the resident was receiving the medication four times a day, at 8:00 AM, 2:00 PM, 8:00 PM and 2:00 AM, instead of as a PRN. The resident was also prescribed Promethazine 25 mg, one tablet three times a day PRN for dizziness. The facility documented on the August 2008 MAR that the resident was receiving the medication three times a day - AM, Noon and PM. Employee #1 stated the resident asked for the medications every day so she was documenting them as a regularly scheduled medication. A metal lock box in the medication storage cabinet found at 10:30 AM contained medications in small plastic cups labeled with resident names. Employee #1 reported the cups contained evening medications for five residents and that she had prepared the medications. The medication cup for Resident #4 contained one tablet each of Tramadol HCL and Promethazine. Resident #5 had a medication cards containing Antivert 25 mg, one tablet to be given as needed for dizziness and Percocet, one tablet to be given	Y 878		

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Y 878	Continued From page 3 as needed for pain. Neither medication was listed on the resident's August 2008 MAR. The resident also had a medication card of Valium 5 mg tablets prescribed to be given at bedtime. Hand written at the top of the card was "PRN" and the medication was not listed on the resident's August 2008 MAR The resident was admitted on 8/18/08 from another group home and there were no original or change order prescriptions in the resident's file. Employee #1 was unable to provide any information concerning the medications and why they were not being given to the resident. Severity: 2 Scope: 3	Y 878		
Y 885 SS=C	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication. This Regulation is not met as evidenced by: Based on observation, interview and record review on 8/29/08, the facility did not ensure	Y 885		

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Y 885	Continued From page 4 medications for 2 of 2 residents were destroyed. Findings include: The discharge file for Resident #10 indicated the resident was admitted on 5/2/08 and died on 5/6/08. A plastic zip-lock bag containing eight bubble pack cards of the resident's medications (Plavix, Furosemide and Lipitor) was found in the facility's medication storage cabinet. The caregiver reported she had called the pharmacy, but they would not take the resident's medications back and she had not destroyed the medications. Resident #5 was admitted on 8/18/08. A bag of medications for the resident included Phenergan 25 mg tablets. The medication expired on 6/26/08 and had not been destroyed by the facility when the resident was admitted. Severity: 1 Scope: 3	Y 885		
Y 921 SS=E	449.2748(2) Medication Storage NAC 449.2748 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. This Regulation is not met as evidenced by: Based on observation and interview on 8/29/08, the facility did not ensure the refrigerated medications for 1 of 2 residents were kept in a locked box. Findings include:	Y 921		

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Y 921	Continued From page 5 Resident #9 was a hospice client and three of the resident's medication were found stored unsecured in the kitchen refrigerator: a bottle of Morphine Sulfate (Roxanol), a plastic bag with 28 vials of Albuterol for use in a nebulizer, and a bottle of Lorazepam. The Lorazepam did not have a label and the caregiver reported the medication was for Resident #9. Refrigerated medications for Resident #3 were in a locked metal box. The caregiver stated there was not enough room in the box for Resident #9's medications, but the box appeared to be large enough to store both resident's medications. Severity: 2 Scope: 2	Y 921		
Y 923 SS=F	449.2748(3)(b) Medication Container NAC 449.2748 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (b) Kept in its original container until it is administered. This Regulation is not met as evidenced by: Based on observation and interview on 8/29/08, the facility did not ensure medications were kept in their original container for 5 of 7 residents. Findings include:	Y 923		

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Y 923	Continued From page 6 During the review of the facility's medication storage cabinet, an unlocked metal box was found to contain five plastic cups labeled with the names of Residents #1, #2, #4, #6, and #7. Employee #1 admitted she had set up the residents evening medications during the morning medication administration. Severity: 2 Scope: 3	Y 923		
YA895 SS=C	449.2744(1)(b) Medication/MAR NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect the current order or prescription of the resident's physician. This Regulation is not met as evidenced by: Based on record review and interview on 8/29/08, the facility failed to ensure the medication administration records (MARs) for 7 of 8 residents were accurate.	YA895		

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YA895	Continued From page 7 Findings include: Review of resident MARs revealed the administration of 8:00 AM medications by Employee #1 for Residents #1, #2, #3, #4, #5, #6, and #7 were not documented as being given the morning of the survey. The employee reported she typically initialed the MARs in the evening each day instead of at the time she gave the medications. Resident #3 was prescribed Citalopram 40 mg tablet in the morning and the pill was in an 8:00 AM bubble pack with her other morning medications. Employee #1 stated she wrote medication instructions on the resident's August 2008 MAR, listed the medication to be given at bedtime, and was documenting the medication as being given at bedtime. The resident was also prescribed Lisinopril 40 mg tablet in the morning and the medication bottle contained the 40 mg tablets. The medication was listed on the MAR as a 20 mg dose. Resident #4 was prescribed Metoprolol 25 mg, one tablet to be given two times a day. The medication was listed on the resident's August 2008 MAR, but the caregivers had not initialed it as being given the whole month of August. Review of the resident's medication bottle indicated the medication was being given. Severity: 1 Scope: 3	YA895		
YA908 SS=D	449.2746(2)(a-f)PRN Medication Record NAC 449.2746 2. A caregiver who administers medication to a resident as needed	YA908		

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YA908	Continued From page 8 shall record the following information concerning the administration of the medication: (a) The reason for the administration; (b) The date and time of the administration; (c) The dose administered; (d) The results of the administration of the medication; (e) The initials of the caregiver; and (f) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician. This Regulation is not met as evidenced by: Based on record review and interview on 8/29/08, the facility did not ensure "as needed" (PRN) medications for 2 of 2 residents with PRN medications were appropriately documented. Findings include: Resident #4 was prescribed Tramadol HCL 50 mg, one tablet every six hours PRN for pain. The resident's August 2008 medication administration record (MAR) showed the medication as being given every day at 8:00 AM, 2:00 PM, 8:00 PM and 2:00 AM from 8/1/08 to 8/28/08; therefore, it was not being administered as a PRN medication and the facility was not documenting the reason for the administration or the results of the administration. The resident was also prescribed Promethazine 25 mg, one tablet three times a day PRN for dizziness. The August 2008 MAR showed the medication as being given everyday from 8/1/08 to 8/28/08 in the AM, NOON and PM.	YA908		

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YA908	Continued From page 9 The facility was not documenting the time, the reason or the results of the administration. Resident #5 was admitted on 8/18/08. Her medication container contained three bubble packs cards with "PRN" written at the top. The three PRN medications were not listed on the resident's August 2008 MAR. Severity: 1 Scope: 3	YA908		